South Dakota Board of Nursing
South Dakota Department of Health
4305 South Louise Avenue Suite 201
Sioux Falls SD 57106-3115
(605) 362-2760 Fax: (605) 362-2768

Application to *Request Equivalency of Education* for 75-Hour Nurse Aide Training

Nursing Students may request to meet the 75-hour Nurse Aide training program requirement by equivalency of education pursuant to ARSD 44:74:02:16. South Dakota Board of Nursing (SDBON) grants approval for students actively or previously enrolled in Board-approved nursing education programs as students are prepared using curricula that include nursing theory and clinical instruction which meet the 75-hour Nurse Aide training program content required in ARSD 44:74:02:15.

SDBON will send written notice as to whether the student: (1) is *granted* approval to waive the Nurse Aide training program and is eligible to schedule the written and manual competency evaluations for nurse aides through the South Dakota Healthcare Association; or (2) is *denied* approval to waive the Nurse Aide training program and why.

RNs and LPNs do not need to complete Nurse Aide training or evaluations to be placed on the South Dakota CNA registry.

Student/ Nurse Name: First:_____ Middle:_____ Last: _____

Mailing Address:_____ City_____ State_____ Zip_____

Telephone: Home: (___)_____ Cell: (___)_____ Other: (___)_____

Email:_____ **Date of Birth**:_____

Social Security #: _____

Disciplinary Information:

If "YES" is answered to any of the disciplinary questions, please attach a detailed explanation. You must also submit copies of charges or citations and ALL communication with (to and from) the citing agency AND the court jurisdiction, including evidence of completion/compliance with court requirements.

1.	Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or adjudication, suspended imposition of sentence with respect to a felony, misdemeanor, or petty offense other than minor traffic violations that have not previously been reported to the Department of Health?	☐ Yes	☐ No
2.	Have you ever had an allegation against you for abuse, neglect, or misappropriation of property?	☐ Yes	☐ No
3.	Is there any pending charge(s) against you with respect to a felony, misdemeanor, or petty offense other than minor traffic violations?	☐ Yes	☐ No
4.	Are you currently being investigated or is disciplinary action pending against any license(s) or certificate(s) held by you?	☐ Yes	☐ No
5.	Has any license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action?	☐ Yes	☐ No
6.	Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital, nursing facility, or other healthcare provider entity?	☐Yes	☐ No
7.	Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?	☐ Yes	☐ No
8.	Have you ever been treated for abuse or misuse of any alcohol or chemical substance?	☐ Yes	☐ No
9.	Have you ever experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care?	☐ Yes	☐ No
10.	Do you currently owe child support arrearages in the amount of $1,000 or more?	☐ Yes	☐ No
11.	Have you ever had action taken against you by the Office of Inspector General (OIG)?	☐ Yes	☐ No

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Submit with this application:

☐ Copy of student's school transcript, grade report, or other school documentation supporting request
The student must have completed a nursing course(s) on fundamental nursing concepts and skills

OR

☐ Provide RN/LPN license number and state/jurisdiction of that license (may be current or inactive/expired license)

Number: _____ State: _____ Expiration Date: _____

(Note: South Dakota Board of Nursing will verify the licensure status of the nurse; if a nurse has had any disciplinary action, BON staff will review and determine whether or not the individual may be placed on the South Dakota Nurse Aide Registry.)

Applicant Signature: _____ **Date:** _____

Send this completed application and supporting documentation to the South Dakota Board of Nursing.

Director of Nursing or Nursing Faculty Member must attest for the nursing student that an approval for waiver of Nurse Aide training for this individual is appropriate. Complete and sign:

Nursing Facility: _____

Name / Title of DON or Faculty Member: _____

Address: _____

City ST Zip: _____

Telephone: _____ **Email:** _____

DON or Nursing Faculty Signature: _____ **Date:** _____

This section to be completed by the South Dakota Board of Nursing

Date Application Received:	Date Application Denied:
Date Approved:	Reason for Denial:
Board Representative:	Date Notice Sent to Student and / or Nursing Facility: